

**REPORT ON THE HEALTHCARE
INFORMATION NETWORKS &
TECHNOLOGIES (HINT) INITIATIVES
IN NEW JERSEY**

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EXECUTIVE SUMMARY

To facilitate increased efficiency in an inefficient, fragmented health care system with duplicative, cumbersome and often incompatible administrative systems the New Jersey Legislature adopted Chapter 154 of the Laws of 1999, an act concerning health information electronic data interchange technology, commonly known as the “HINT” law. HINT is an acronym coined from the 1995 study on Healthcare Information Networks and Technologies (the Study), prepared for the Legislature by Thomas Edison State College and the New Jersey Institute of Technology. This study predicted that the use of technology would result in enormous savings and increased efficiency in the exchange of health care data. Since the release of this 1995 Study, the state of New Jersey has pursued a twofold strategy to realize these goals: provision of annual funding to the Department of Health and Senior Services (DHSS) for strategic investments in the information technology (IT) infrastructure of the health care system; and passage of Chapter 154, or the HINT law, which created a regulatory framework to standardize administrative transactions related to health insurance. The HINT law:

- ☐ Set standards governing the timeframe for insurance carriers to pay “clean” claims submitted by providers or insureds, with rules to be adopted by the Department of Banking and Insurance (DOBI);
- ☐ Directed DOBI to adopt, by regulation, standards for both electronic and paper health insurance enrollment and claims forms. Commencement of the time period from which DOBI was charged with development of the rules was linked to the federal government’s adoption of electronic administrative simplification standards pursuant to the Health Insurance Portability and Accountability Act (HIPAA).
- ☐ Directed the Commissioner of DHSS, in consultation with the Commissioner of DOBI, to form an advisory board to make recommendations to the commissioners on health information electronic data interchange technology policy and measures to protect the confidentiality of medical information;

- ☐ Directed the Commissioner of DHSS, in conjunction with the Commissioner of DOBI and in consultation with the Advisory Board, to present an annual report to the Governor and the Legislature on the development and use of health information electronic data interchange technology in New Jersey; and
- ☐ Directed Thomas Edison State College to study and monitor issues concerning health information electronic data interchange technology and report to the Governor and Legislature.

With the passage of the HINT law and its ongoing infrastructure investments, New Jersey has gained a reputation nationally as a state that has a vision for how the health care system can be improved through the systematic and standardized use of electronic technology for data exchange.

This is the Commissioner of DHSS' first report to the Governor and Legislature. It focuses on the following:

- ☐ New Jersey's progress in adopting uniform standards for administration transactions;
- ☐ federal activity and rulemaking in the areas of health care administrative transaction and code standards. data security and protecting the privacy of individuals' health information ;
- ☐ formation of the HINT Advisory Board;
- ☐ stakeholder concerns;
- ☐ strategic investment in IT infrastructure in New Jersey; and
- ☐ future priorities and recommendations.

With respect to the state and federal regulatory changes, New Jersey's HINT and the federal HIPAA rules governing administrative transaction standards have been adopted. Implementation of the federal HIPAA rule on transaction standards, originally scheduled for October 16, 2002, was delayed for an additional year. For those entities able to substantiate a need for more time and a commitment to full implementation by October 16, 2003, H.R.3323 permitted a yearlong delay.

Many carriers, particularly those operating in multiple states, expressed concern that implementation of HINT transactions standards would be required much earlier than implementation of these HIPAA standards. Given the federal postponement of administrative simplification standards, New Jersey heard renewed concerns from stakeholders who would prefer to follow only the federal timetable. In response to these concerns, the Department of Banking and

Insurance (DOBI) issued Bulletin No. 02-01 in February 2002, acknowledging the need for a coordinated approach between HIPAA and HINT. Accordingly, DOBI indicated its Commissioner would grant an extension to the HINT deadlines for payers who submitted to DOBI by October 1, 2002, a certification that the company requested a federal HIPAA extension, and was also participating in statewide strategic implementation of HINT requirements. Both nationally and in New Jersey most parties have taken advantage of this opportunity for longer lead time to implement the new administrative transaction standards.

It should be noted that, under HIPAA, regulations governing administrative transactions and code sets, and privacy and security rules, are to be adopted. These other HIPAA rules either have different effective and compliance dates or have not yet been finalized. For example, the HIPAA privacy standards took effect April 14, 2003. Some parties advocated for a federal law that would delay the implementation of all the HIPAA rules governing health care transactions until the last of these rules took effect, resulting in one overall implementation date, but the Congress did not adopt this approach. As a result of the April implementation date for the federal privacy standards and the October implementation date for the administrative transaction standards, 2003 is a critical year for HIPAA, and accordingly also for HINT.

In accordance with the HINT law, the New Jersey electronic transaction standards for health insurance claims and enrollment are required to be identical to the federal standards. Unlike HIPAA, HINT also requires DOBI to establish uniform forms for *paper* claims and enrollment transactions, and the rules adopted on October 1, 2001 accomplish this. Medicare paper claims forms already widely in use are the HINT standard for paper claims. Enrollment forms have proven more challenging to standardize, given that these have tended to be unique to each carrier. After carefully considering input from providers, both before and after its initial proposal of HINT administrative simplification rules, DOBI developed what should be a workable standard without unduly burdening carriers.

Among New Jersey stakeholders, there are varying degrees of concern over the challenge of implementing these federal and state rules. Carriers and larger providers, such as hospitals, are generally aware of the requirements and are well into the planning and implementation stage. Smaller providers, including physician and other professional practices, are often unaware of the requirements, or struggling to understand what they must do to comply, and where they can find affordable, reliable expert assistance in compliance. Carriers are very concerned that the lack of readiness of these small providers to adopt the HINT/HIPAA administrative transactions may result in significant cash flow problems for these providers, as claims that they submit starting in October are rejected for failure to meet the data and format requirements of HINT/HIPAA.

All stakeholders are concerned about the expense of compliance, with some projecting costs that will exceed those associated with Y2K. At the same time, there is general consensus that, despite the up front expense, all parties in the health care system will eventually benefit from the use of standardized electronic administrative transactions. The best contribution the State can make to this effort is continued outreach and education, particularly to smaller providers, about their need to comply with both the federal and state requirements. DOBI, through the HIPAA Implementation Task Force, which grew out of the HINT Advisory Board, has focused on bringing together the relevant parties to assure successful implementation of the HIPAA/HINT administrative transaction standards in New Jersey.

Stakeholders express far greater concerns with other aspects of HIPAA, particularly the rules governing the protection of individually identifiable health information (the "Privacy Rule."). Covered entities, as defined in the HIPAA privacy rule, must comply by April 14, 2003. An exception is made for smaller health plans, which have until April 14, 2004, to comply. The initial version of the Privacy Rule, adopted in April, 2001, was extraordinarily comprehensive and complex, and engendered great controversy between those who believed they did not go far enough and those – including many in the health care provider community - who believed they went too far and would have interfered with the routine delivery of health care services. To address concerns such as those of perceived interference with the delivery of health care services, the U.S. Department of Health and Human Services (USDHHS) proposed modifications to the rules in March 2002 that were adopted later in the year. The resulting final Privacy Rule remains very complex and comprehensive, although several provisions of particular concern to providers have been modified to reduce the potential for interference with treatment. Covered entities under the HIPAA Privacy Rule, which includes providers, clearinghouses and payers, must comply with the final rule as of April 14, 2003. They are also required to enter into "business associate" agreements that extend these protections to vendors they use who receive individual health information in order to perform tasks on behalf of payer or provider.

People, with IT technical expertise, generally consider the HIPAA Security Rule, also effective April 21, 2003, reasonable, although the costs associated with compliance may be burdensome. Once again, smaller entities lacking staff dedicated to IT functions are at a disadvantage compared to larger entities with more resources and expertise to devote to implementation of the Security Rule.

The HINT Advisory Board is specifically charged under the HINT law with considering measures to protect the confidentiality of medical information. The general view of members of the Advisory Board is that New Jersey's attention should be focused on clarifying and complying with the requirements of the federal law and rules. Although HIPAA allows states to set more stringent standards to protect an individual's health information, given the

comprehensiveness of the HIPAA requirements and the implementation challenges they present to payers and providers, New Jersey should not be considering any additional state-specific initiatives in the area of privacy at this time. DHSS and DOBI concur with this assessment and recommendation.

Overall, HINT and HIPAA represent a comprehensive regulatory approach to standardizing requirements for health care administrative transactions. At this time DHSS and DOBI do not believe that any additional regulatory authority is required to promote the goals of administrative simplification.

HINT refers not only to the 1999 law, but also to the ongoing, strategic investments the state of New Jersey is making in upgrading the IT infrastructure of health care, particularly public health. Some of the fruits of these investments are already being realized. For example, many states collect hospital discharge data from the claims billing systems of hospitals. These data are widely used, both within and outside state governments, for health care facility planning, health services research, tracking of disease data of relevance to public health, etc. Utilizing HINT funding, DHSS invested in the development of a web-enabled system for hospitals to submit this data, which was rolled out statewide in 2001. This system, which is the first one in the nation to allow submission via the Internet, significantly reduces the hospitals' reporting costs, while improving both timeliness and accuracy of the data. Under the old system, data generally lagged the close of the calendar year by at least fifteen months; under the new system the lag is closer to three months, making the data much more useful for public health and planning purposes. Some of the savings realized in this system have been reinvested in developing emergency department discharge data reporting by hospitals for the three million ED visits that do not result in an admission. A pilot begun in the fall of 2002 successfully tested the system, and rules to implement it statewide have been proposed. A supplemental module is being developed to allow tracking of certain diagnoses that might be suggestive of bioterrorism events or natural disease outbreaks that might raise public health concerns.

New Jersey's Local Information Network and Communications System (NJ-LINCS) is a system of state and local public health professionals, physicians, hospitals, emergency responders and others interconnected by personal computer, the Internet and other electronic technologies. It has proven to be a vital element of the Department's strategy for dealing with bioterrorism, such as the anthrax events of 2001, as well as naturally occurring public health problems, such as the emergence of Severe Acute Respiratory Syndrome (SARS) in recent months. HINT funding was used to build the basic infrastructure of NJ-LINCS, which is now supported from federal bioterrorism preparedness funding. Twenty-two strategically positioned local health agencies serve as information/communication hubs for NJ-LINCS, with over 20,000 organizations statewide participating in exchange of information. Furthermore, web sites have been

developed that provide users with extensive public health information as well as over 400 Internet links to important public health information.

Development efforts are underway in the areas of web-based communicable disease reporting and registering childhood immunizations. Funds have also been used to pilot an electronic death certificate and to help hospitals upgrade their telecommunications infrastructure. HINT funding has, therefore, played a very constructive role in providing seed money to jumpstart crucial investments in modernizing the IT infrastructure of health care and public health in New Jersey.

REPORT on the HINT INITIATIVES IN NEW JERSEY

Background - The Development of “HINT”

In 1993, a Health Information Electronic Data Interchange Technology (HINT) Advisory Council was formed by members of the Legislature together with other essential stakeholders from government, providers, health care facilities, health care payers, and members of industry. Its purpose was to weigh the value of creating an electronic data interchange (EDI) to handle health care claims information. In order to explore the effectiveness of electronic systems in reducing administrative costs, the Legislature commissioned a study to be performed jointly by the New Jersey Institute of Technology and Thomas Edison State College.

In March 1995, the Advisory Council reported the potential for enormous savings to be realized within the health care industry upon implementation of EDI. The Council's report was based on findings from the “HINT” study, published in 1995, which concluded that using electronic data interchange technology in health care could reduce administrative costs. Savings were estimated to result from replacing non-standardized, complex, de-centralized health care transactions with standardized electronic forms. The work of the HINT Advisory Council resulted in the passage of the HINT law, enacted on July 1, 1999.

The Act, commonly known as “HINT,” requires the Commissioner of the Department of Banking and Insurance (DOBI), in consultation with the Commissioner of the Department of Health and Senior Services (DHSS), to:

- Establish by regulation timeframes for payment of “clean” insurance claims by health insurance carriers. These are the so-called “prompt pay” provisions of the HINT law.
- In addition, the HINT law calls for the establishment of a timetable by the Commissioner of DOBI, tied to the federal Department of Health and Human Services' adoption of rules establishing electronic standards for health care administrative transactions. HINT requires DOBI to specify one set of standard health care enrollment and claims forms in paper and electronic formats to be used by each carrier and third party administrator (TPA) in all health care transactions completed within the State, with the electronic formats conforming to the federal standards.
- Carriers are further required to mandate – contractually - that health care providers file all claims on behalf of covered persons.

Further, the law calls for the Commissioner of DHSS to establish an Advisory Board to make recommendations to the commissioners on health information electronic data interchange technology policy and confidentiality measures for medical information.

Finally, the law also requires Thomas Edison State College to continue to study and monitor the effectiveness of electronic data interchange technology in reducing administrative costs, improving health care quality through the increased use of information systems, and securing the privacy and confidentiality of transferred medical information.

In addition to the regulatory framework mandated by the HINT law, the State has also since 1996 supported development of EDI infrastructure in New Jersey's healthcare system through annual appropriations to DHSS, New Jersey Institute of Technology, and Thomas Edison State College. DHSS has used its funding to build EDI infrastructure both within and outside of the Department.

The Health Insurance Portability and Accountability Act – HIPAA

On August 21, 1996, Congress passed Public Law 104-191, the Health Insurance Portability and Accountability Act (HIPAA). Although this law was primarily focused on creating national standards for group health insurance, it also included provisions to promote administrative simplification and protect privacy of individuals' health information. This act requires the U.S. Department of Health and Human Services (USDHHS) to develop national standards applicable to health care providers, plans and clearinghouses for electronic health care transactions.

Sections 261 through 264 of HIPAA are known as the "administrative simplification" provisions. The major part of the administrative simplification provisions is found in section 262 of HIPAA wherein a new Part C of Title XI of the Social Security Act is enacted. Section 262 seeks to facilitate efficiencies and cost savings for the health care industry by directing USDHHS to issue standards for electronic exchange of information as well as protections for the security, confidentiality and integrity of health care information.

In 1998, the USDHHS first proposed a series of regulations to create a standard architecture for health care claims transactions by electronic data interchange (EDI). The proposed rules, which were to promote administrative simplification, applied transaction and code sets for processing health care claims, unique provider and insurer identifiers, and privacy and security standards.

On August 17, 2000, the first regulation within the administrative simplification set of rules, Standards for Electronic Transactions 65 FR 50312 (the "Transaction Rule") was adopted, with an effective date of October 17, 2002.

Formal adoption of this rule triggered the provisions of the HINT law requiring DOBI to adopt rules governing the timetable for NJ carriers to adopt the federal standards. Rules promulgated by DOBI became final in October of 2001, with an effective date of October 1, 2002.

However, in December of 2001, federal legislation allowed affected entities to delay HIPAA administrative simplification implementation for one year, until October 16, 2003, if they successfully make the case that such a delay is needed. Although detailed information explaining how they will come into compliance, including budget, schedule, work plan, and implementation strategy for doing so was required to get the extension, the standard for an extension was set comparatively low, and it appears to be the case that compliance was postponed until October, 2003 for the industry as a whole. After October 16, 2003, Medicare will only accept paper claims from providers seeking payment under a very limited set of circumstances.

Additionally, even prior to the initial implementation deadline, the federal government has already adopted a rule amending the Electronic Health Care Transactions and Code Sets. The Final Rule was published in the February 20, 2003 Federal Register. Although the amendments respond to various concerns raised about the initial code sets, their recent adoption makes the task of adopting the new standards by October 16th even more complicated for covered entities. This is particularly so since the federal government is requiring all covered entities to have started software and systems testing for the transaction and code sets no later than April 16, 2003.

The federal rule establishing a unique identifier for employers to use in electronic health information transactions was adopted on May 31, 2002 and must be implemented by all covered entities, except small health plans, by July 30, 2004. Small health plans have an additional year. The rule governing security standards for electronic information systems has also been adopted and covered entities will be expected to comply no later than April 21, 2005. Once again, there is an exception for small health plans.

Comparison of HINT and HIPAA

New Jersey's HINT law is both broader and narrower than HIPAA. It is broader in that it requires standardization of paper as well as electronic transactions forms and formats. It includes prompt payment standards, and it requires insurance carriers to require providers to file claims on behalf of their insured patients.

On the other hand, the HINT law is also narrower than HIPAA, because it applies directly only to insurance carriers and TPAs, not to providers or clearinghouses. It also does not apply to public insurance programs, such as

Medicare and Medicaid. And, HINT calls for standards only for enrollment and claims transactions, while HIPAA covers not only a broader range of administrative transactions, but also requires that electronic security and general privacy standards be promulgated.

HINT Advisory Board

DHSS convened the HINT Advisory Board in May, 2000. Members are listed in Attachment 1. The Board formed two subcommittees, one focused on administrative simplification issues and one focused on privacy issues. The Board as a whole held its last meeting in the summer of 2001. It was agreed then that the Board would recommend that New Jersey focus its privacy activities on compliance with the new federal rules, rather than on adding any further state requirements to the new federal ones, given the very large implementation challenges associated with the federal rules. Since that time DOBI has continued to collaborate closely with a work group initially derived from Advisory Board members focusing on administrative simplification, the HIPAA Implementation Task Force. (Members listed at Appendix A)

HINT Administration Simplification Rules

The HINT law requires DOBI to adopt rules for all health insurance payers authorized to do business in New Jersey that:

- Establish one set of standard health care enrollment and claims forms in paper and electronic formats (with the electronic format specified under the HIPAA rules);
- Fix timetables for the implementation of the use of enrollment and claims forms in all health related transactions within the state;
- Create a procedure for operational status reports to the Department where payers report their ability to achieve compliance with the timetable for processing of the standard enrollment and claims information;
- Establish procedures to dispose of requests for extension of time and waivers from compliance filed by payers unable to comply with timetables.

DOBI is also required to report on payer compliance, extensions of time and waivers granted.

In an effort to provide payers with an understanding of HIPAA requirements as well as to gain an understanding of plans for the development of HINT/HIPAA compliance systems, DOBI issued Order A00-138 on August 29, 2000. The Order required all affected payers to report to DOBI specific details about the extent of any compliance plans. Through this process, DOBI learned

that most payers were establishing project development teams and were making specific plans to achieve compliance. In addition, a number of payers also provided a listing of concerns about the HINT/HIPAA administrative simplification implementation.

On March 5, 2001, DOBI proposed draft rules to comply with the HINT requirements. After reviewing the numerous comments submitted on the proposed rules, DOBI finalized the rules and adopted them effective October 1, 2001.

Some members of the HINT Advisory Board initially expressed great concern at the prospect that New Jersey might mandate adoption of the new electronic transaction standards substantially in advance of the federal timetable. While all are agreed with the goal of standardization, some stakeholders express concern with the upfront costs, as well as the feasibility of an accelerated schedule. Respondents to a survey of HINT Advisory Board members indicated that this is a “daunting task” to be completed within a required two year implementation period. Concerns were voiced that state compliance is required within a shorter period than the HIPAA timeline currently allows. One respondent stated that to shorten the federal implementation timeframe would require covered entities to engage in minimal training efforts, install abridged protection mechanisms with less built in integrity, short shrift internal coordination activities as well as policy and procedure content related to privacy regulations. Additionally, carriers operating in multiple states expressed concern about having to change their systems for New Jersey only.

This issue became moot when the state created a process that allowed New Jersey payers to follow the federal compliance timetable. When the year-long delay of HIPAA implementation for most entities became a reality, there was renewed interest in delaying HINT implementation to a time conforming more closely with the new federal schedule. As a result, DOBI issued Bulletin No. 02-01 in February, 2002, acknowledging the need for a coordinated approach between HIPAA and HINT. Accordingly, DOBI indicated in the Bulletin that it would grant an extension to the HINT deadlines for payers who submitted to DOBI by October 1, 2002, a certification that the company had requested a federal HIPAA extension, and was also participating in statewide strategic implementation of HINT requirements. New Jersey payers have taken advantage of this opportunity for an extension.

Education and Outreach Efforts Related To Administrative Simplification

The State has been active since 2000 in education and outreach to promote awareness of the requirements of both HIPAA and HINT. In October, 2000 DHSS sponsored a one day forum featuring national experts on HIPAA and local experts on HINT. The HINT Advisory Board, formed that same year, provided a

forum for disseminating information to stakeholders through their associations and other representatives. Since 2002, DOBI, working with the HIPAA Implementation Task Force that is an offshoot of the Advisory Board, has taken an aggressive leadership role in education, outreach and specific problem-solving to support HIPAA/HINT implementation. For example, on August 9, 2002, DOBI hosted a volunteer group of interested parties to discuss administrative simplification testing efforts in New Jersey. Various payers, providers, clearinghouses, EDI vendors and interested associations were included. DOBI has been committed throughout this process to communicating with all interested parties the need to start statewide testing efforts in a timely fashion. While DOBI should not, and cannot, do the testing or certify that a covered entity is HIPAA-compliant, it is appropriate for DOBI to facilitate a dialogue between parties interested in forming testing agreements and partnerships. Thus, while the various private parties retain the responsibility for compliance, DOBI has undertaken this effort to provide a platform for them to join together in the necessary testing structures.

One of the most significant achievements of the Implementation Task Force that DOBI has sponsored has been the adoption of a Common Companion Guide for use with HIPAA transactions. This document represents an agreement among New Jersey payers, providers, clearinghouses and other interested parties on standards for dealing with many of those instances where the HIPAA transaction sets are not fully defined. Thus, the parties have agreed not to reject claims that are submitted with certain missing data elements, so long as the claims are consistent with the Common Companion Guide. The federal government has accepted this approach, and is even considering a similar solution nationally in the absence of fully defined standards. It is uncertain if they will act in time, however. Furthermore, some authorities have suggested that USDHHS may be uncertain about exactly what will constitute “compliance” with HIPAA’s transaction standards. The New Jersey Common Companion Guide avoids most of these issues and positions covered entities in this state well to undertake the federally-required certification and testing.

In its education and outreach efforts DOBI has also worked closely with the members of NJSHORE (NJ’s Strategic HIP/Healthcare Organization and Regional Effort). NJSHORE was organized by the private sector in September 2002 to help address statewide HIPAA administrative simplification compliance efforts by promoting collaboration among key stakeholders and documenting on its website best practices in compliance. NJSHORE was approved shortly after it was founded as the New Jersey regional effort for assistance with HIPAA implementation. This designation came from the nationally recognized Workgroup for Electronic Data Interchange-Strategic National Implementation Process (WEDI/SNIP), which has worked closely with the federal government on HIPAA issues since the passage of the federal law. Active members of NJSHORE include, in addition to DOBI and other state agencies, the Centers for Medicaid and Medicare Services, Thomas Edison State College, the New Jersey

Hospital Association, the NJ Council on Teaching Hospitals, the Medical Society of New Jersey, the Primary Care Association of New Jersey, Horizon Blue Cross/Blue Shield, Amerigroup, Horizon Mercy, Americhoice, Armanti Financial Services, Strategic System Solutions, and Infotech Global.

In addition to these global efforts, there are numerous targeted education and outreach activities that have gone on for the past several years. Targeted audiences include providers, carriers, employers and professional healthcare associations. Larger organizations such as carriers and larger hospital systems, are most aware of the impending changes and have implementation plans well underway.

Associations representing the various types of providers have been very active in disseminating information to their members, through bulletins, seminars and, in some cases, their websites. The New Jersey Hospital Association website, for example, features HIPAA continuously updated compliance information prominently, including hyperlinks to other informative sites.

Carriers have been very aggressive not only in gearing up their own operations for compliance, but also in offering education to office-based health care providers they contract with about HIPAA's requirements. Methods used range from special provider bulletins to seminars for providers and their administrative staff. Despite these intensive outreach efforts, however, smaller providers appear to be much less aware of the HIPAA administrative simplification requirements, and even when they are aware, are unsure or lack the resources to undertake implementation on their own. Horizon Blue Cross/Blue Shield of New Jersey reports that some experts nationally estimate that as many as 50% of providers will not be ready to comply on October 16, 2003. Its own surveys of its contracted physician offices suggests that physicians have been more focused on compliance with HIPAA's privacy requirements than administrative simplification. Horizon has called for even more aggressive, high-level efforts to raise provider awareness, in order to avert potential cash-flow problems for providers who find, post-October 16th, that they are unable to get paid due to submission of non-compliant claims.

PRIVACY ISSUES

The HINT law requires that the Advisory Board consider measures to protect the confidentiality of medical information. At the same time, in enacting HIPAA, Congress recognized that implementation of administrative simplification necessitates the establishment of rules for protection of privacy and certain individually identifiable health information. Although states have previously enacted laws to safeguard privacy, these laws vary from state to state. There are also considerable gaps in protection afforded. Therefore, as health

information systems continued to evolve, Congress determined that a federal rule was needed to establish a set of national privacy standards that provided a basic level of protection of individually identifiable health information for all Americans.

Section 264 (b) of the HIPAA law required the Secretary of USDHHS to develop and submit to the Congress recommendations for:

- The rights that an individual who is a subject of individually identifiable health information should have;
- The procedures that should be established for the exercise of such rights; and
- The uses and disclosures of such information that should be authorized or required.

The Secretary's privacy recommendations were submitted to Congress on September 11, 1997, but in the absence of Congress enacting legislation governing standards by the law's imposed deadline, the Secretary was authorized to promulgate regulations containing such standards. USDHHS initially published proposed rules establishing Standards for Privacy of Individually Identifiable Health Information in November 1999 and issued a final rule in December 2000, which took effect on April 14, 2001. As required by the HIPAA law, most covered entities are required to comply with the final Privacy Rule's provisions by April 14, 2003. An additional year is granted for smaller entities.

The HIPAA privacy rule as initially proposed was viewed as extraordinarily comprehensive, and complex, and it spawned great controversy. There were those who believed that the rule did not go far enough to protect individuals' health information from disclosure, as well as those who believed that it went too far and would have actually interfered with health care delivery, for example, by unduly restricting the ability of health care providers to communicate with each other. Although USDHHS adopted the privacy rule as drafted from the previous Administration, Secretary Tommy Thompson indicated his intention to amend some portions of this adopted Privacy Rule. A modified rule was published on August 14, 2002 and subsequently adopted.

For the typical HIPAA covered entity, the Privacy Rule requires the following types of activities:

- Notifying patients about their privacy rights and how their individual health information can be used;

- Adopting and implementing procedures to protect the privacy of individual health information within the provider's practice, health care facility or health insurance plan;
- Training employees so that they understand what procedures are required to protect privacy;
- Designating someone to be responsible within the organization for ensuring privacy protection procedures are adopted and followed;
- Securing patient records containing individually identifiable health information so that they are not readily available to those who do not have a need to see them.

USDHHS describes the Privacy Rule as "scalable," i.e., depending on the size of the covered entity, the above activities are either comparatively simple or large and complex. For example, within a physician practice the designated privacy official may also be the office manager who has many other duties, while in a large insurance carrier or hospital this may be a person whose full-time job is ensuring privacy protection.

There are several exceptions to the general rule adopted by Congress under HIPAA that affirm federal provisions and preempt state law that is contrary to the federal rule. One of these exceptions allows states to retain primary authority when state laws or rules that relate to the privacy of individually identifiable health information are more stringent than the federal privacy regulations. In the case of New Jersey, however, HIPAA's privacy rules are more stringent than New Jersey's Insurance Information Practices Act (N.J.S.A. 17:23A-1).

Despite the modifications made to the federal Privacy Rule, many carriers and providers remain very concerned about the effort that is being required in order to comply with the Rule. In light of this, HINT Advisory Board members generally believe that attention in New Jersey should be focused on clarifying and complying with the requirements of the federal law and rules for the next few years. Members believe New Jersey should not be considering any additional, more stringent state-specific initiatives in the area of health information privacy at this time. DHSS and DOBI concur with this assessment and recommendation.

In an effort to gather "real world" information and experiences concerning the implications and challenges of meeting administrative simplification regulations (including privacy requirements) among covered entities early in the implementation process, members of the HINT Advisory Board completed a questionnaire developed by DHSS (attached). The majority of respondents noted that their organizations had established, or were in the process of creating, a privacy or security officer position. Also, most organizations surveyed had

completed a privacy/security assessment and drafted policies concerning access to and maintenance of medical records.

In assessing examples provided through the Advisory Board survey of HINT/HIPAA implementation activities related to privacy regulations, it is generally noted that entities were in the process of implementing:

- security system features such as password protections;
- two and three-level physical security systems;
- training sessions on the confidentiality and integrity of customer data for workforce personnel who have access to protected health information;
- new policy and procedure development regarding use and disclosure and sanctions for violations; and
- assessment tools for in-house gap analysis to assist in identifying privacy needs.

Respondents typically were larger organizations. Once again the issue of compliance awareness and capacity among smaller providers has been a key issue. Associations such as the Medical Society of New Jersey have been very active in communicating with their members in a variety of ways to prepare them to meet the compliance deadlines. For HIPAA in general numerous consultants have emerged that market their ability to covered entities to ensure their compliance with the many different HIPAA regulations. For small providers, however, there remains the challenge not only of paying for such consulting expertise, but being sufficiently knowledgeable about HIPAA to distinguish the skill levels among various consultants.

Enhancing the Health System IT Infrastructure

High Speed Internet Access

Technology internet access grants were among the earliest HINT funding initiatives to promote an IT infrastructure to support greater efficiency and effectiveness in the health care system. They helped pave the way for use of EDI by New Jersey's acute care hospitals. Over a period of three years, starting in 1997, the Department provided one-time start-up funds for hospitals to contract with internet service providers for connection of high-speed lines. Prior to this HINT initiative, most NJ hospitals barely had basic dial-up service. Through these grants, many hospitals first acquired the capacity to transmit large volumes of data five times faster than with conventional modems. Growing acceptance of the technology resulted in a variety of data being transferred over these high speed lines. On-line nursing education and

other internet continuing education courses are being undertaken. Access to relevant databases and medical libraries is available. These electronic interfaces increase efficiency within the hospital enterprise and IT area, reduce administrative costs, and foster the sharing of clinical data.

New Jersey Hospital Discharge Data Collection System

Building on the theme of reducing healthcare costs while increasing efficiency, one of the first HINT initiatives undertaken was to streamline and redesign New Jersey's inpatient hospital discharge data collection system. HINT funds were used to pay for the one-time development of the software and related systems. Operational costs continue to be borne by hospitals, but are significantly reduced. Previous collection efforts relied on tape and diskettes submission with back-end edits and manual turnaround documents. This system collects data on more than 1.5 million discharges per year. A web-enabled system, the New Jersey Discharge Data Collection System (NJDDCS) that streamlines the inpatient data submission and collection process was implemented in 2001, and per record discharge costs to hospitals have decreased from \$1.26 to 50 cents. This was the nation's first web-enabled system for collection of hospital discharge data. The redesigned system increases timeliness and accuracy of the data by including up-front edits. Whereas the old system typically required fifteen months or longer to close out the data collection for a calendar year, the web-enabled system can accomplish this in three months. Hospital discharge data is used for a wide variety of public health and planning purposes by public and private organizations, and the increased accuracy and timeliness of this data set has proven very valuable.

In the fall of 2002, DHSS began a pilot at a small but representative group of hospitals of an expansion of its web-based hospital discharge data collection system to include Emergency Department (ED) discharge data. The present system collects emergency department data only if the visit results in an admission to the hospital as an inpatient. Annually there are three million emergency department visits to New Jersey hospitals, and on average, 19% of these visits lead to an inpatient admission. For public health purposes it is very important to understand the nature of the other 2.4 million annual emergency department visits, in order to assess who is using emergency departments, as well as how many visits are for true emergencies. The pilot has successfully tested the system's ability to collect emergency department data, and DHSS has proposed rules that would implement this system statewide. Given the efficiency of the web-enabled system, even with the addition of emergency department data, hospitals will still pay less to support the discharge data collection system than they did several years ago. DHSS is also developing, using federal bioterrorism funding, a special reporting module that will enable tracking of certain emergency department diagnoses that might be suggestive of bioterrorism or other public health problems. Although discharge data is derived from billing data and is not "real time" data, this module will, at a very modest

additional cost, significantly increase the amount of information available to DHSS in a very short timeframe.

A key ingredient for the success of this project has been partnerships developed between the hospitals and the department. The effect of these accomplishments is that we now have a model and industry example for other states. In December, 2002, DHSS staff were asked to present a report at the annual meeting of the National Association of Health Data Organizations on the process used to develop the NJDDCS, as well as the system's capabilities.

New Jersey Local Information Network and Communications System (NJ-LINCS)

NJ~LINCS is a system of state and local public health professionals, physicians, hospitals, emergency responders and others interconnected by personal computer, the Internet, and other electronic technologies. It supports the exchange of data and information used to enhance the identification and containment of diseases and hazardous conditions that threaten the public's health. HINT funding also supported a study and development of the NJ LINCS strategic plan that has helped DHSS identify information, communication and technology needs. Many of plan's recommendations have subsequently been implemented, resulting in the successful growth and expansion of NJ~LINCS as a statewide public health information and communication system. As public health and health data access systems continue to grow in the future, NJ~LINCS will be used as the platform on which disease surveillance, electronic reporting, communications, and response will be built.

Twenty-two strategically positioned local health departments serve as public health disease surveillance coordination and information/ communication hubs. Each LINCS agency has established a Community Health Alert and Information Network for the distribution and response to public health alerts and advisories. Over 20,000 public health, health care and emergency response organizations participate in these networks. Web sites have been developed that provide users with over 250 pages and 400 links to important public health data and information. NJ~LINCS' success has allowed the department to leverage other state and federal funds that enhance technology and surveillance. In the aftermath of the September 11th terrorist attacks and during the management of West Nile virus, anthrax cases, and, most recently, suspected cases of Severe Acute Respiratory Syndrome (SARS) cases in New Jersey, the LINCS system has proven invaluable in disseminating crucial information in a timely manner.

New Jersey EASE

New Jersey Easy Access Single Entry (New Jersey EASE) has completely revised the way information is disseminated to the senior citizen population. New

Jersey EASE provides seniors with a single access point to retrieve information regarding state services. It facilitates the use of hospital discharge planning and patient referral and provides better and more accurate tracking of client status over time through standard reports. Managed service delivery is based upon client assessment data and eligibility criteria. The program provided assistance with the more than 180 community agencies that offer NJ EASE core services. Through the funding from HINT, seniors can now communicate electronically with case managers. These connections have been established in each county. Over the years, HINT has supported hardware, software, wiring and other connective services to develop the NJEASE infrastructure.

New Jersey Immunization Information System

Immunization registries are important tools for improving timely immunization of pre-school children. The State created an electronic registry on a pilot basis in 1996, the New Jersey Immunization Information System (NJIIS), but had difficulty deploying the system on a comprehensive basis. There are currently 4,000 potential immunization providers in New Jersey, including pediatricians and school nurses. Using HINT funds for one-time development, DHSS introduced in January, 2003 a new, web-based immunization registry that is more user-friendly to this large and diverse group of providers, including physicians in private practice.

This system integrates immunization data from numerous sources (e.g., WIC, clinics, private practices, hospitals, etc.) and authorizes health care providers to access and, if appropriate, update a child's immunization record. It also enables parents to obtain immunization information for their children. It provides immunization histories, demographic data and provider information. Several levels of security protect this individual health information. A key feature of this registry is that it allows medical providers, or their agents, to automatically and electronically remind patients when specific vaccines are due or past due. In the future, the system could be expanded beyond local health departments to hospitals and major commercial laboratories in the State. Reviews of the revamped NJIIS by external evaluators and the CDC have rated it one of the top four of the 26 state population-based immunization registries. DHSS is now pursuing legislative changes that will enable wider use of this excellent electronic registry.

Communicable Disease Reporting System (CDRS)

Through the funding related to HINT, as well as the New Jersey Domestic Security Preparedness Act of 2001, New Jersey's first web portal for communicable disease reporting is being implemented. It supercedes an outdated reporting system composed of stand-alone databases created through

keying in information from paper-based reports. These databases ran on out-dated computer systems, were not as up-to-date as effective public health response to communicable disease outbreaks requires, and produced data that could not easily be generated across multiple platforms.

On January 14, 2002, the Department rolled out the new Communicable Disease Reporting System (CDRS). It was designed to enhance timely disease reporting and improved communications among the state, local health departments and, ultimately, health care providers. It facilitates the investigation of emerging public health problems, reduces staff time required for processing paper forms, and eliminates data redundancy, duplicative data collection and maintenance efforts. It also encourages uniform collection of reportable disease information and improves compliance with disease reporting from labs, hospitals and private practice physicians. As a result, it strengthens New Jersey's ability to respond to either natural or bioterrorism-induced outbreaks of disease.

A pilot test included local health departments in Atlantic, Bergen, Burlington, Camden, Gloucester, Hunterdon, Monmouth, Middlesex and Somerset Counties, as well as the city of Newark. Some hospitals in these same counties also participated in the pilot. Overall, the pilot was successful, local health departments liked the system, and no major problems or difficulties were uncovered. In November, 2002 CDRS went "on-line" with Laboratory Corporation of America (LabCorp) for electronic submission of laboratory data for reportable communicable diseases. CDRS receives a daily electronic feed of reports on findings from New Jersey specimens from LabCorp's North Carolina headquarters. All local health departments and hospitals are expected to be linked to CDRS by the end of 2003. When fully implemented, all commercial laboratories, hospitals, participating physician offices, local health departments, and other approved users will have access to one central collection point.

Assessment of IT Intrastructure Investments

Overall, the State's funding of these strategic investments has provided crucial seed money for developing the healthcare IT infrastructure. At a time when there is recognition of a persistent underinvestment in the public health infrastructure nationally, New Jersey's foresight and investments in health system electronic technology have won widespread praise.

APPENDIX A

HINT ADVISORY BOARD And IMPLEMENTATION TASK FORCE MEMBERSHIP LISTS

HINT Advisory Board

| Name/Title (*indicates alternate) | Affiliation/Address |
|--|--|
| George Rhoades, MD Director | UMDNJ School of Public Health Piscataway-New Brunswick Campus |
| Michael Waterbury, Director of Claims *Scott Schwartz | Oxford Health Insurance |
| Tom Fitzpatrick, Ph.D. Director of EDI Services | Horizon Health Insurance |
| Michele Guhl | NJ Association of Health Plans |
| Lawrence Sharrott, Chief Information Officer | AtlantiCare Health Systems |
| Joseph Carr Chief, Information Officer | NJ Hospital Association |
| Paul Weber | Medical Society of New Jersey |
| Carol Kientz Executive Director *Richard Wusthoff | Home Health Assembly of New Jersey |
| June Duggan President | NJ Association of Non-Profit Homes for the Aging |
| Paul Langevin President *Tom Dorner | NJ Association of Health Care Facilities |
| Andrea Augenbaugh | NJ State Nurses Association |
| Susan Mattler Finance and Administration | University of Medicine and Dentistry of NJ |
| Mary Swigar, MD, Chair, IRB | UMDNJ-RWJ Medical School |
| Mark Gordon Director, Special Studies | Thomas Edison State College |
| Donald Sebastian Associate Provost, Research and Development | NJ Institute for Technology |
| Tom Terry, Associate VP Information Resource Development *Pat Bronigan | NJ Institute for Technology |
| George Laufenberg | NJ Carpenter's Funds |

| | |
|--|---------------------------------------|
| *Mary Willis | |
| Frank Solis | |
| John Jacobi Associate Director/Associate Professor Health Law and Policy Program | Seton Hall University |
| Daniel Santo-Pietro Director, Communications Office | Hispanic Director's Association of NJ |
| James Watkins | American Home Products |
| Daniel Regenye, LINCS Coordinator, Health Planner *Joseph Przywara | |

IMPLEMENTATION TASK FORCE

Allan Adams
Senior Vice President of Technology
and Founder
CareMedic Systems, Inc

Joseph A Carr
New Jersey Hospital Association

Shari Back
Saint Barnabas Health Care System

Maureen E. Carson, MM
BDO Seidman, LLP

James Baker
Lourdes Health System

Lisa Dalton
Virtua Health Information Services

David Barzillia
Advanced Data Systems

Sabrina Dobbins
Medical Manager

Donald Bechtel
Oakland Corporation Center

Tom Dorner
Director of Reimbursement
Information Service
Health Care Association of New
Jersey

Cindy Biggio
Virtua Health Support Services
Center

Lewis D Bivona, Jr.
Amper, Politziner & Mattia, PA

Rosanne Dovgala
Senior Vice President, Government
Affairs
Armanti Financial Services, LLC

Patrick Brannigan
Office of Management & Operations
Office of the Governor

Suzanne Dusak
Virtua Health Support Services
Center

Evelyn Brewer
Halley Exchange (Per Se)

Kimberly Evans
QuadraMed

Robert Cabnet, MPA
NJ Health Advocate Volunteer Effort
Jewish Family & Vocational Service
of Middlesex County

Catherine Farley
Division of Consumer Affairs
Department of Law & Public Safety

IMPLEMENTATION TASK FORCE

Tom Fitzpatrick, Ph.D.
Horizon Health Insurance

Carol Kientz
Home Health Assembly of New
Jersey

Kenneth W Fody
AmeriHealth

Andrea Kivlehan
Advanced Data Systems

Patrick J Gallagher
New Jersey Medicaid Program

Cynthia Korman
Strategic System Solutions, LLC

Judith M Gladney
AtlantiCare

Lee Ledbetter
Siemens Health Services

Stacey Goldston
Moses & Singer LLP

Jim LoPresti
WebMD

Rudy Gontek
System Business Office
Saint Barnabas Health Care System

Linda Malek
Moses & Singer LP

Mark Gordon
Director, Special Studies
Thomas Edison State College

Seth Masters
Director of Business Development
Gaffey & Associates

Tom Gordon
Virtua Health Information Services

McKesson
HBOC

David Hockley
Physicians Support Systems

Bud Meadows
Medical Manager

Ted Itzkowitz
STI Computer Systems

John Murdoch, II

Lois Katz
Virtua Health & Rehab Center

IMPLEMENTATION TASK FORCE

Diane Nelson
Director of A/R Management
Virtua Health

Carolyn Torre
NJ State Nurses Association

Marc S Newman
Vice President, System Integration &
Planning
Saint Barnabas Health Care System

Robert Sand
PriceWaterhouseCoopers

Martian Sedlak
Aetna

Bob Perlitz
AVP/HIPAA Compliance Officer
Empire Blue Cross Blue Shield

Jay Shah
MDOOffice (JHJ)

Teresa Ries
Cydata (HBOC & Co.)

Dan Short
Department of Human Services

Stuart P Schiffman
Assistant VP, Patient Business
Services
Virtua Health

Peter Water
Provider Transaction Management

Lawrence Sharrott
President, InfoShare (CIO-ACMC)
AtlantiCare

Paul Weber
Director, Finance and Administration
Medical Society of New Jersey

Christina A Stearns
Princeton Public Affairs Group, Inc

Wayne Wilson
Director, Medicare Part A Operations
Blue Cross Blue Shield of
Tennessee, Inc

Lee Ann Stemmer
National Council for Prescription
Drug Program

Kepa Zubeldia, M.D.
Our Fearless Leader

Pat Tomsho
Misys Healthcare (Medic)
Misys Fast Services

APPENDIX B

HINT LEGISLATION, Chapter 154

CHAPTER 154

An Act concerning health information electronic data interchange technology, supplementing Titles 17, 26 and 54 of the Revised Statutes and Titles 17B and 54A of the New Jersey Statutes.

Be It Enacted *by the Senate and General Assembly of the State of New Jersey:*

C.17B:30-23 Timetable for implementation of electronic receipt, transmission of health care claim information; standard forms.

1. a. (1) The Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, shall establish, by regulation, a timetable for implementation of the electronic receipt and transmission of health care claim information by each hospital, medical or health service corporation, individual and group health insurer, health maintenance organization, dental service corporation, dental plan organization and prepaid prescription service organization, respectively, and a subsidiary of such corporation, insurer or organization that processes health care benefits claims as a third party administrator, authorized to do business in this State.

The Commissioner of Banking and Insurance shall establish the timetable within 90 days of the date the federal Department of Health and Human Services adopts rules establishing standards for health care transactions, including: health claims or equivalent encounter information, including institutional, professional, pharmacy and dental health claims; enrollment and disenrollment in a health plan; eligibility for a health plan; health care payment and remittance advice; health care premium payments; first report of injury; health claim status; and referral certification and authorization, respectively, pursuant to section 262 of Pub.L.104-191 (42 U.S.C.s.1320d et seq.). The commissioner may adopt more than one timetable, if necessary, to conform the requirements of this section with the dates of adoption of the federal rules.

(2) The timetable for implementation adopted by the commissioner shall provide for extensions and waivers of the implementation requirement pursuant to paragraph (1) of this subsection in cases when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a hospital, medical or health service corporation, individual or group health insurer, health maintenance organization, dental service corporation, dental plan organization or prepaid prescription service organization, respectively, or a subsidiary of such corporation, insurer or organization that processes health care benefits claims as a third party administrator, authorized to do business in this State.

(3) The Commissioner of Banking and Insurance shall report to the Governor and the Legislature within one year of establishing the timetable pursuant to this subsection, on the number of extensions and waivers of the implementation requirement that he has granted pursuant to paragraph (2) of this subsection, and the reasons therefor.

b. The Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, shall adopt, by regulation for each type of contract, as he

deems appropriate, one set of standard health care enrollment and claim forms in paper and electronic formats to be used by each hospital, medical or health service corporation, individual and group health insurer, health maintenance organization, dental service corporation, dental plan organization and prepaid prescription service organization, and a subsidiary of such corporation, insurer or organization that processes health care benefits claims as a third party administrator, authorized to do business in this State.

The Commissioner of Banking and Insurance shall establish the standard health care enrollment and claim forms within 90 days of the date the federal Department of Health and Human Services adopts rules establishing standards for the forms.

C.17:48-8.4 Hospital service corporation to receive, transmit transactions electronically.

2. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a hospital service corporation, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a hospital service corporation, its subsidiary or its covered persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a hospital service corporation or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all group and individual contracts issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a hospital service corporation shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a hospital service corporation or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by a subscriber or that subscriber's agent or assignee if the contract provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is

earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

- (a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;
- (b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;
- (c) there is no dispute regarding the amount claimed;
- (d) the payer has no reason to believe that the claim has been submitted fraudulently; and
- (e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract.

(2) If all or a portion of the claim is denied by the payer because:

- (a) the claim is an ineligible claim;
- (b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;
- (c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
- (d) the payer disputes the amount claimed; or
- (e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract, the payer shall notify the subscriber, or that subscriber's agent or assignee if the contract provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or subscriber, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on

or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by a subscriber for payment of benefits under an insured hospital service corporation contract for which the financial obligation for the payment of a claim under the contract rests upon the hospital service corporation.

C.17:48A-7.12 Medical service corporation to receive, transmit transactions electronically.

3. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a medical service corporation, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a medical service corporation, its subsidiary or its covered persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a medical service corporation or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all group and individual contracts issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a medical service corporation shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's

option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a medical service corporation or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by a subscriber or that subscriber's agent or assignee if the contract provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

- (a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;
- (b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;
- (c) there is no dispute regarding the amount claimed;
- (d) the payer has no reason to believe that the claim has been submitted fraudulently; and
- (e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract.

(2) If all or a portion of the claim is denied by the payer because:

- (a) the claim is an ineligible claim;
- (b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;
- (c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
- (d) the payer disputes the amount claimed; or
- (e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract, the payer shall notify the subscriber, or that subscriber's agent or assignee if the contract provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or subscriber, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by a subscriber for payment of benefits under an insured medical service corporation contract for which the financial obligation for the payment of a claim under the contract rests upon the medical service corporation.

C.17:48E-10.1 Health service corporation to receive, transmit transactions electronically.

4. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health service corporation, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health service corporation, its subsidiary or its covered persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health service corporation or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all group and individual contracts issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health service corporation shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a health service corporation or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by a subscriber or that subscriber's agent or assignee if the contract provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

- (a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;
- (b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;
- (c) there is no dispute regarding the amount claimed;
- (d) the payer has no reason to believe that the claim has been submitted fraudulently; and
- (e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract.

(2) If all or a portion of the claim is denied by the payer because:

- (a) the claim is an ineligible claim;
- (b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;
- (c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
- (d) the payer disputes the amount claimed; or
- (e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract, the payer shall notify the subscriber, or that subscriber's agent or assignee if the contract provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or subscriber, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by a subscriber for payment of benefits under an insured health service corporation contract for which the financial obligation for the payment of a claim under the contract rests upon the health service corporation.

C.17B:26-9.1 Health insurer to receive, transmit transactions relative to individual policies electronically.

5. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's

satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health insurer, its subsidiary or its covered persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all individual policies issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the policy.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a health insurer or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by an insured or that insured's agent or assignee if the policy provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the policy;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;

(d) the payer has no reason to believe that the claim has been submitted fraudulently; and

(e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the policy.

(2) If all or a portion of the claim is denied by the payer because:

(a) the claim is an ineligible claim;

(b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;

(c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;

(d) the payer disputes the amount claimed; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the policy,

the payer shall notify the insured, or that insured's agent or assignee if the policy provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or insured, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by an insured for payment of benefits under an insured policy for which the financial obligation for the payment of a claim under the policy rests upon the health insurer.

C.17B:27-44.2 Health insurer to receive, transmit transactions relative to group policies electronically.

6. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer, or a subsidiary that

processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health insurer, its subsidiary or its covered persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all group policies issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health insurer shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the policy.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a health insurer or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by an insured or that insured's agent or assignee if the policy provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

- (a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the policy;
- (b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;
- (c) there is no dispute regarding the amount claimed;
- (d) the payer has no reason to believe that the claim has been submitted fraudulently; and
- (e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the policy.

(2) If all or a portion of the claim is denied by the payer because:

- (a) the claim is an ineligible claim;

(b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;

(c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;

(d) the payer disputes the amount claimed; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the policy,

the payer shall notify the insured, or that insured's agent or assignee if the policy provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or insured, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by an insured for payment of benefits under an insured policy for which the financial obligation for the payment of a claim under the policy rests upon the health insurer.

C.26:2J-8.1 Health maintenance organization to receive, transmit transactions electronically.

7. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health maintenance organization, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a health maintenance organization, its subsidiary or its covered enrollees.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health maintenance organization or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all group and individual health maintenance organization coverage for health care services issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health maintenance organization shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a health maintenance organization or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by an enrollee or that enrollee's agent or assignee if the health maintenance organization coverage for health care services provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the health maintenance organization coverage for health care services;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;

(d) the payer has no reason to believe that the claim has been submitted fraudulently; and

(e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the health maintenance organization coverage for health care services.

(2) If all or a portion of the claim is denied by the payer because:

(a) the claim is an ineligible claim;

(b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;

(c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;

(d) the payer disputes the amount claimed; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the health maintenance organization coverage for health care services, the payer shall notify the enrollee, or that enrollee's agent or assignee if the health maintenance organization coverage for health care services provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or enrollee, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by an enrollee for payment of benefits under an insured health maintenance organization contract for which the financial obligation for the payment of a claim under the health maintenance organization coverage for health care services rests upon the health maintenance organization.

C.17:48C-8.1 Dental service corporation to receive, transmit transactions electronically.

8. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental service corporation, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a dental service corporation, its subsidiary or its covered persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental service corporation or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all group and individual contracts issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental service corporation shall require that health care providers file all claims for payment for dental services. A covered person who receives dental services shall not be required to submit a claim for payment, but

notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a dental service corporation or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by a subscriber or that subscriber's agent or assignee if the contract provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

- (a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;
- (b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;
- (c) there is no dispute regarding the amount claimed;
- (d) the payer has no reason to believe that the claim has been submitted fraudulently; and
- (e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract.

(2) If all or a portion of the claim is denied by the payer because:

- (a) the claim is an ineligible claim;
- (b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;
- (c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
- (d) the payer disputes the amount claimed; or
- (e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract, the payer shall notify the subscriber, or that subscriber's agent or assignee if the contract provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or subscriber, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by a subscriber for payment of benefits under an insured dental service corporation contract for which the financial obligation for the payment of a claim under the contract rests upon the dental service corporation.

C.17:48D-9.4 Dental plan organization to receive, transmit transactions electronically.

9. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a dental plan organization, its subsidiary or its covered enrollees.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to

section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all group and individual contracts issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization shall require that health care providers file all claims for payment for dental services. A covered person who receives dental services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a dental plan organization or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by an enrollee or that enrollee's agent or assignee if the contract provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

- (a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;
- (b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;
- (c) there is no dispute regarding the amount claimed;
- (d) the payer has no reason to believe that the claim has been submitted fraudulently; and
- (e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract.

(2) If all or a portion of the claim is denied by the payer because:

- (a) the claim is an ineligible claim;
- (b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;
- (c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
- (d) the payer disputes the amount claimed; or
- (e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract, the payer shall notify the enrollee, or that enrollee's agent or assignee if the contract provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of

the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or enrollee, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by an enrollee for payment of benefits under an insured dental plan organization contract for which the financial obligation for the payment of a claim under the contract rests upon the dental plan organization.

C.17:48F-13.1 Prepaid prescription service organization to receive, transmit transactions electronically.

10. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a prepaid prescription service organization, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise

comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a prepaid prescription service organization, its subsidiary or its covered enrollees.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a prepaid prescription service organization or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all contracts issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a prepaid prescription service organization shall require that health care providers file all claims for payment for health care services. A covered person who receives health care services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154), a prepaid prescription service organization or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by an enrollee or that enrollee's agent or assignee if the contract provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42U.S.C.s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

- (a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;
- (b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;
- (c) there is no dispute regarding the amount claimed;
- (d) the payer has no reason to believe that the claim has been submitted fraudulently; and
- (e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract.

(2) If all or a portion of the claim is denied by the payer because:

- (a) the claim is an ineligible claim;

(b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;

(c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;

(d) the payer disputes the amount claimed; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract, the payer shall notify the enrollee, or that enrollee's agent or assignee if the contract provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or enrollee, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by an enrollee for payment of benefits under an insured prepaid prescription service organization contract

for which the financial obligation for the payment of a claim under the contract rests upon the prepaid prescription service organization.

C.26:1A-15.1 Advisory board on electronic data interchange technology policy.

11. The Commissioner of Health and Senior Services, in consultation with the Commissioner of Banking and Insurance, shall establish an advisory board to make recommendations to the commissioners on health information electronic data interchange technology policy and measures to protect the confidentiality of medical information. The members of the board shall include, at a minimum, representation from health insurance carriers, health care professionals and facilities, higher education, business and organized labor, and health care consumers. The members of the board shall serve without compensation but shall be entitled to reimbursement for reasonable expenses incurred in the performance of their duties.

C.26:1A-15.2 Annual report to Governor, Legislature.

12. The Commissioner of Health and Senior Services, in conjunction with the Commissioner of Banking and Insurance, shall present an annual report to the Governor and the Legislature on the development and use of health information electronic data interchange technology in New Jersey. The report shall be prepared in consultation with the advisory board established pursuant to section 14 of P.L.1999, c.154 (C.26:2H-12.12). The report shall include any recommendations, including proposals for regulatory and legislative changes, to promote the development and use of health information electronic data interchange technology in this State.

C.45:1-10.1 Responsibility of health care professionals for filing claims.

13. Effective 12 months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health care professional licensed pursuant to Title 45 of the Revised Statutes is responsible for filing all claims for third party payment, including claims filed on behalf of the licensed professional's patient for any health care service provided by the licensed professional that is eligible for third party payment, except that at the patient's option, the patient may file the claim for third party payment.

a. In the case of a claim filed on behalf of the professional's patient, the professional shall file the claim within 60 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23).

b. In the case of a claim in which the patient has assigned his benefits to the professional, the professional shall file the claim within 180 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23). If the professional does not file the claim within 180 days of the last date of service for a course of treatment, the third party payer shall reserve the right to deny payment of the claim, in accordance with regulations established by the Commissioner of Banking and Insurance,

and the professional shall be prohibited from seeking any payment directly from the patient.

(1) In establishing the standards for denial of payment, the Commissioner of Banking and Insurance shall consider the good faith use of information provided by the patient to the professional with respect to the identity of the patient's third party payer, delays in filing a claim related to coordination of benefits between third party payers and any other factors the commissioner deems appropriate, and, accordingly, shall define specific instances where the sanctions permitted pursuant to this subsection shall not apply.

(2) A professional who fails to file a claim within 180 days and whose claim for payment has been denied by the third party payer in accordance with this subsection may, in the discretion of a judge of the Superior Court, be permitted to refile the claim if the third party payer has not been substantially prejudiced thereby. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to file the claim with the third party payer within 180 days.

c. The provisions of this section shall not apply to any claims filed pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).

d. A health care professional who violates the provisions of subsection a. of this section may be subject to a civil penalty of \$250 for each violation plus \$50 for each day after the 60th day that the provider fails to submit a claim. The penalty shall be sued for and collected by the Division of Consumer Affairs in the Department of Law and Public Safety pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

C.26:2H-12.12 Responsibility of health care facilities for filing claims.

14. Effective 12 months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) is responsible for filing all claims for third party payment, including claims filed on behalf of the health care facility's patient for any health care service provided by the health care facility that is eligible for third party payment, except that at the patient's option, the patient may file the claim for third party payment.

a. In the case of a claim filed on behalf of the health care facility's patient, the health care facility shall file the claim within 60 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23).

b. In the case of a claim in which the patient has assigned his benefits to the health care facility, the health care facility shall file the claim within 180 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23). If the health care facility does not file the claim within 180 days of the last date of service for a course of treatment, the third party payer shall reserve the right to deny payment of the claim, in accordance with regulations established by the

Commissioner of Banking and Insurance, and the health care facility shall be prohibited from seeking any payment directly from the patient.

(1) In establishing the standards for denial of payment, the Commissioner of Banking and Insurance shall consider the length of delay in filing the claim, the good faith use of information provided by the patient to the health care facility with respect to the identity of the patient's third party payer, delays in filing a claim related to coordination of benefits between third party payers and any other factors the commissioner deems appropriate, and, accordingly, shall define specific instances where the sanctions permitted pursuant to this subsection shall not apply.

(2) A health care facility which fails to file a claim within 180 days and whose claim for payment has been denied by the third party payer in accordance with this subsection may, in the discretion of a judge of the Superior Court, be permitted to refile the claim if the third party payer has not been substantially prejudiced thereby. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to file the claim with the third party payer within 180 days.

c. The provisions of this section shall not apply to any claims filed pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).

d. A health care facility which violates the provisions of subsection a. of this section may be subject to a civil penalty of \$250 for each violation plus \$50 for each day after the 60th day that the health care facility fails to submit a claim. The penalty shall be sued for and collected by the Department of Health and Senior Services pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

C.17B:30-24 Regulations.

15. The Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, shall adopt regulations to effectuate the purposes of sections 1 through 10 of this act, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). To the extent practicable, the regulations shall include any provisions the commissioner deems appropriate that seek to reduce the amount of, or to consolidate, the paper forms sent by hospital, medical, health and dental service corporations, commercial insurers, health maintenance organizations, dental plan organizations and prepaid prescription service organizations to health care providers and covered persons.

C.17B:30-25 Thomas A. Edison State College to study, monitor effectiveness of electronic data interchange technology.

16. Thomas A. Edison State College shall study and monitor the effectiveness of electronic data interchange technology in reducing administrative costs, identify means by which new electronic data interchange technology can be implemented to effect health care system cost savings, and determine the extent of electronic data interchange technology use in the State's health care system.

The Departments of Health and Senior Services and Banking and Insurance shall cooperate with and provide assistance to the college in carrying out its study pursuant to this section.

The college shall report to the Legislature and the Governor from time to time on its findings and recommendations.

Repealer.

17. Sections 78, 79, and 80 of P.L.1991, c.187 (C.17B:26-12.1, 17B:27-44.1 and 26:2J-5.1) are repealed.

18. This act shall take effect immediately

Approved July 1, 1999.

APPENDIX C

HINT MEMBER SURVEY, January 2001

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| Name | |
| Title | |
| Organization/Institution | |

Part I: HINT/HIPAA Administrative Simplification

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| Provide Examples of HINT/HIPAA Administrative Simplification Implementation including EDI |
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| Identify Actual or Anticipated Compliance Difficulties in HINT/HIPAA Administrative Simplification Implementation including EDI |
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| Describe education and outreach efforts regarding HINT/HIPAA Administrative Simplification Implementation including EDI. Include targeted audience and availability of materials to non-organizational/institutional members. |
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| <i>Has your organization/institution (or your members') identified a person with responsibility for HINT/HIPAA administrative simplification compliance?</i> |
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| Name | |
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Part II: Privacy

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| Has your organization/institution (or your members') identified a HIPAA Privacy Officer? Who? |
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| <i>Has your organization/institution (or your members') completed a privacy/security assessment?</i> |
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| Does your organization (or your members') have written policies concerning access to medical records? Maintenance of medical records? |
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| Are you (or your members') a covered entity under the Privacy Regulations? (Check) |
| Health Care Payer - <input type="checkbox"/> Health Care Provider Payer <input type="checkbox"/> Health Care Clearinghouse <input type="checkbox"/> |
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| Provide Examples of HINT/HIPAA Implementation Activities related to Privacy Regulations |
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| Identify Actual or Anticipated Compliance Issues or Difficulties in HINT/HIPAA Implementation of the Privacy Regulations |
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| Name | |
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| Describe education and outreach efforts regarding HIPAA requirements related to the Privacy Regulations including audience and availability of materials to non-organizational/institutional members. |
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| Other health system – related IT initiatives concerning administrative simplification not required by HIPPA |
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| Other topics the report should address |
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| Recommendations you would like to see reflected in the report |
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